

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully; the correctness is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

170c

10734

282

## CERTIFICATE OF DEATH

Reg. Dist. No.....

## 1. PLACE OF DEATH:

County.....

City or town..... *St. Marys*  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death?..... *26 hours*

Hospital, institution, or street address where death occurred:

*St. Marys Hospital*How long in hospital or institution?..... *26 hours*

## 3. (a) FULL NAME

*Thomas Ashton*

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

*Male Colored Widowed*6.(b) Name of husband or wife..... *Mary Catharine*

7. Birth date of deceased (mo., day, yr.)

*Dec - 4 - 1904*

6.(c) If alive, give age..... years

8. AGE: Years Months Days If less than one day

*43 10 20 . . . . . hrs. . . . . min.*9. Birthplace..... *Clementon, St. Marys Maryland*  
(Town, county, and state)

10. Usual occupation.....

*Labor*

11. Industry or business.....

*same*

MOTHER

12. Name..... *Johh miles*

13. Birthplace.....

*St. Marys Co*

14. Maiden name.....

*Sara Ashton*

15. Birthplace.....

*St. Marys Co*

16. Informant.....

*Spa Mansie Young*

Address.....

*Morganza Maryland*

17. Burial, cremation, or removal. Which?

*Burial*Date thereof..... *Oct 24 1948*  
(month) (day) (year)

Cemetery or crematory.....

*St. Joseph Cemetery*

Location.....

*Morganza Maryland*

18. Funeral director.....

*W. E. Hartley Son*

Address.....

*Leonardtown Maryland*

19. (Date rec'd by registrar)

*10/27/48**Caucasian*

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... *Maryland* County..... *St. Marys*City or town..... *Morganza*  
(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

*219-16-0266*

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... *Oct 25*

1948 at 1:30 p.m.

21. I CERTIFY that death occurred on the date above stated; that ~~patient~~ deceased from19..... *on 10-25-1948*and that I last saw him..... *alive*

19

Immediate cause of death..... *Intoxication  
Injuries*

DURATION

*24 hrs*Due to..... *Automobile accident*

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Data of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... *Accident* Date of..... *Oct 24 48*

Where did injury occur?

(City or town) *St. Marys* (County) *St. Marys* (State) *MD*

Injured at home, farm, industry, public place (where?)

Means of injury *Automobile accd.* Injured at work? *No*

23. SIGNATURE.

M. D. or other *Branch & Russell Acting*Address *Leonardtown MD* Date signed *10-26-48*



1  
mr  
11  
PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10725

## CERTIFICATE OF DEATH

Reg. Dist. No. 282

## 1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution or street address where death occurred:

St. Mary's Hosp.

How long in hospital or institution?

10 hrs.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

James A. Bowman

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

male Colored married

6.(b) Name of husband or wife

Maxine Bowman

7. Birth date of deceased (mo., day, yr.)

Sept. 7, 1917

6.(c) If alive, give age years

8. AGE: Years Months Days If less than one day

31                     hrs.      min.

9. Birthplace

Maryland

(Town, county, and state)

10. Usual occupation

Laborer

11. Industry or business

Charles A. Bowman

MOTHER FATHER

Charles A. Bowman

13. Birthplace

Maryland

14. Maiden name

Frances Myres

15. Birthplace

Maryland

16. Informant

Charles A. Bowman

Address

Chaptico, Md.

17. Burial

Burial Date thereof 10/27/48

(Burial, cremation, or removal. Which?)

(Month) (day) (year)

Cemetery or crematory

St. Joseph Cemetery

Location

Margareta, Md.

18. Funeral director

J. B. Robinson

Address

Leonardtown, Md.

19. 10/25/25

At Crematory

(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct. 25, 1948, at 3:45 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 to 19

and that I last saw him alive on

19

Immediate cause of death

Residual pneumonia

DURATION

12 hrs

Due to

Automobile accident

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

accident Date of Oct. 24, 1948

Where did injury occur?

Helen, St. Mary's, Md.

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

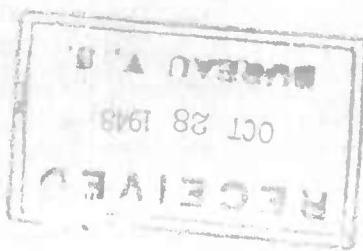
motor vehicle

Injured at work?

23. SIGNATURE

F. F. Greenwell acting M.D. or other

Address Leonardsburg, Md. Date signed 10/25/48



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10726

## CERTIFICATE OF DEATH

Reg. Dist. No. 282

## 1. PLACE OF DEATH:

County ST. MARY'S

City or town VALLEY LEE

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1/16

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

GEORGE HERMAN COPPAGE

4. Sex MALE 5. Color or race white 6. (p) Single, married, widowed, or divorced MARRIED

6. (b) Name of husband or wife Clemetine C. Coppage

7. Birth date of deceased (mo., day, yr.) Aug. 18<sup>th</sup> 1900 6. (c) If alive, give age 58 years

8. AGE: Years 48 Months 1 Days 20 If less than one day hrs. min.

9. Birthplace Drayton St. Mary's Co. Md.

(Town, county, and state)

10. Usual occupation Chamber

11. Industry or business

12. Name John B. Coppage

13. Birthplace St. Mary's Co. Md.

14. Maiden name Susan Elizabeth Duke

15. Birthplace St. Mary's Co. Md.

16. Informant Mrs. Clemetine C. Coppage

Address Valley Lee, Md.

17. Burial Date thereof 10-11-48

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Poplar Hill

Location Valley Lee, Md.

18. Funeral director W. C. MARTINGLEY SONS

Address Leonardtown, Md.

19. 10/10/48 1948 (Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD

County ST. MARY'S

City or town VALLEY LEE

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

219-16-0508

## MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 8 1948 at 4:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. . . . . to 19. . . . .

and that I last saw h . . . . alive on 19. . . . .

Immediate cause of death

Coronary Thrombosis

Due to

Arterio - occlusion

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

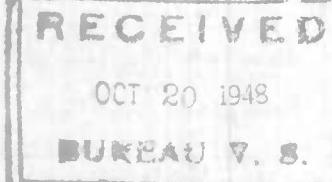
Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address Leonardtown, Md. Date signed 10/10/48



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is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 202

10727

## 1. PLACE OF DEATH:

County *St. Marys*City or town *Torontown*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? *4 years*

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

*William Alfred Fargo*

## 3. (b) Social Security Number

*195-09-7344*

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

*Male white married*

## 6. (b) Name of husband or wife

*Margaret Fargo*6. (c) If alive, give age *73* years

7. Birth date of deceased (mo., day, yr.)

*Sept 24 - 1875*

8. AGE: Years

Months

Days

If less than one day

*73**0**11**hrs.**min.*

9. Birthplace

*Penn*

(Town, county, and state)

10. Usual occupation

*Retired Farmer*

11. Industry or business

*same*

MOTHER FATHER

*Erie Gregory Fargo*

13. Birthplace

14. Maiden name

*Mary Singif*

15. Birthplace

16. Informant

*Margaret Fargo*

Address

*Torontown, Ind.*

17. Burial

*Date thereof Oct 8 1948*  
(Burial, cremation, or removal. Which?)  
(month) (day) (year)

Cemetery or crematory

*St. Pauls M.E.*

Location

*near Torontown, Md.*

18. Funeral director

*W. L. Mattingley Son*

Address

*Torontown, Ind.*

19. Oct 6 48

(Date rec'd by registrar)

*Canadian*

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Pa*County *-*City or town *Wilkes Barre*

(If outside city or town limits, write RURAL and give nearest town)

Street No. *242*

PARRISH

(If rural, give LOCATION)

2. (a) If veteran, name war

## MEDICAL CERTIFICATION

20. DATE OF DEATH

*5 Oct*1948 at 3  $\frac{1}{2}$  M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

15 Aug 1948 to 5 Oct 1948 and that I last saw him alive on 5 Oct 1948

Immediate cause of death

*Cardiac decompensation*Due to *Arteriosclerotic cardiovascular disease*

Due to

Other conditions *Pulmonary tuberculosis*

(Include pregnancy within 8 months of death)

1948  
*24 hours*

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

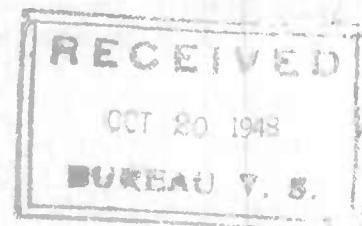
Injured at work?

23. SIGNATURE

*J. Roy Gugher, M.D.*

M. D. or other

Address *Mechanicsville*Date signed *5 Oct 48*



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10728  
280

## CERTIFICATE OF DEATH

Reg. Dist. No.

## 1. PLACE OF DEATH:

County

Dameron

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

m.

White

Sing

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age .....

years

May 7, 1905

8. AGE:

Years

Months

Days

If less than one day

43

5

14

..... hrs. .... min.

9. Birthplace

Virginia

(town, county, and state)

10. Usual occupation

Bacter. flower

11. Industry or business

Agricul. business

12. Name

Unknown

13. Birthplace

Unknown

14. Maiden name

Unknown

15. Birthplace

Unknown

16. Informant

L. O. Finkpatrick

Address

Dameron, Md.

17. Transportation

Date thereof: 10/22/48

(Burial, cremation, or removal, Which?)

Cemetery or crematory

Cathsville, Virginia

Location

Cathsville, Virginia

18. Funeral director

J. B. Robinson

Address

Leonardtown, Md.

19. (Date rec'd by registrar)

10/22/48

Carvalle

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County St. Mary's

City or town Dameron (If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

227-18-5393

## MEDICAL CERTIFICATION

## 2D. DATE OF DEATH

10-21 1948 at 8:15 AM

21. I CERTIFY that death occurred on the date above stated: that deceased from

and that deceased alive on 19..... to 19.....

Immediate cause of death Insultation of body

Due to Farm boy passed over by caterpillar tractor

Due to

Other conditions

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of 10/21/48

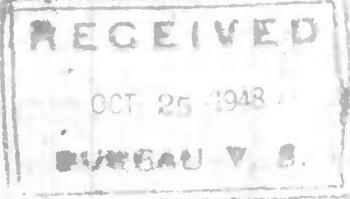
Where did injury occur? Maryland St. Mary's Co. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Farm house self

Means of injury Bicycler's tractor Injured at work? yes

Signature Francis G. Greenwell, Coroner M. D. or other

Address Leonardtown, Md. Date signed 10-22-48



~~Write for  
date~~  
 PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct page is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH  
2411 N. Charles St., Baltimore

11732

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County.....

ST. MARSH

City or town.....

Chesapeake Bay

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

William KENNETH Hopkins

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

m

c

single

6. (b) Name of husband or wife.....

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

Dec 3, - 1923

8. AGE: Years

Month

Days

If less than one day

24

hrs.

min.

9. Birthplace.....

VIRGINIA

(Town, county, and state)

10. Usual occupation.....

LABORER

11. Industry or business

HERBERT Hopkins

12. Name.....

VIRGINIA

13. Birthplace

14. Maiden name.....

ELLEN MAE Young

15. Birthplace

NORTH CAROLINA

16. Informant.....

HELEN E. Smit

Address

E. BECKLEY, W. VIRGINIA

17. Burial, cremation, or removal (Which?)

Burial

Date thereof 11-17-48

(month) (day) (year)

Cemetery or crematory.....

Greenwood

Location.....

E. BECKLEY, W. VIRGINIA

18. Funeral director.....

C. B. T. REED

Address

E. BECKLEY, W. VIRGINIA

19. Date rec'd by registrar

11/18/48

19

(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State W. VIRGINIA County Raleigh

City or town Beckley

(If outside city or town limits, write RURAL and give nearest town)

Street No. ....

(If rural, give LOCATION)

2.(a) If veteran, name war

World War II

## 3. (b) Social Security Number

295-16-6989

## MEDICAL CERTIFICATION

Deferred Drowned

OCTOBER 18, 1948

20. DATE OF DEATH.....

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dead when first seen

and that I last saw him alive on

Immediate cause of death.....

Drowning

Due to.....

Drowning

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Incident Date of deferred

Where did injury occur? ....

Claypool Bay, St. Mary's Co. (County) (State)

Injured at home, farm, industry, public place (where?)

Claypool Bay

Means of injury.....

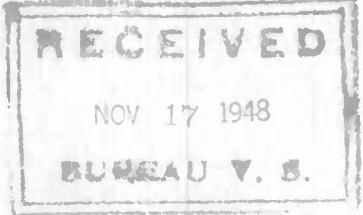
Drowning

Injured at work? Yes

23. SIGNATURE

John J. Doe M. D. or other

Address.....



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10729

## CERTIFICATE OF DEATH

Reg. Dist. No. 282

1. PLACE OF DEATH:  
County..... St. Mary's

City or town..... USNAS, Patuxent River, Maryland  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Two (2) Months

Hospital, institution, or street address where death occurred:

Dispensary, USNAS, Patuxent River, Md.

How long in hospital or Institution? Dead on arrival

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State..... North Carolina County..... Unknown

City or town..... Graham  
(If outside city or town limits, write RURAL and give nearest town)

Street No..... Route # 1.  
(If rural, give LOCATION)

2.(a) If veteran, name war..... None

## 3. (a) FULL NAME

Mc DANIEL, Willard Ashley

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White US	Single

6.(b) Name of husband or wife..... - - -

7. Birth date of deceased (mo., day, yr.) 2-1-27

8. AGE:	Years	Months	Days	If less than one day
	21	8	27	hrs. min.

9. Birthplace..... North Carolina  
(Town, county, and state)

10. Usual occupation..... U. S. Navy

11. Industry or business..... U. S. Navy

12. Name	Unknown
13. Birthplace	

14. Maiden name	Unknown
15. Birthplace	

16. Informant	U. S. Naval Record
Address	

Transportation	Date thereof 10/31/48
(Burial, cremation, or removal. Which?)	(month) (day) (year)

Cemetery or crematory	
-----------------------	--

Location	Burlington, North Carolina
----------	----------------------------

18. Funeral director	P. B. Robinson
Address	Leonardtown, Md.

19. (Date rec'd by registrar)	10/31/48	Caucasian
	19.	Registrar

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH 30 October 1948 at 3:28 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from not attended 19. to 19.

and that I last saw h. alive on 19.

Immediate cause of death..... WOUND, Gunshot, Chest DURATION

Due to..... being shot by night watchman

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Homicide Date of 10-30-48

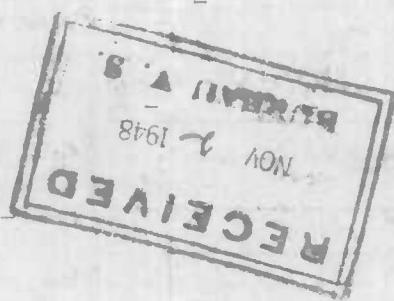
Where did injury occur? Charlotte Hall, StMary's Md. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Public Place

Means of Injury Shot by night watchman at work? No

23. SIGNATURE R. R. BONAR LCDR MC USN M. D. or other

Address USNAS? Patuxent River, Md. Date signed 10-30-48



DEATH

10730

MARYLAND STATE DEPARTMENT OF HEALTH DEATH  
CERTIFICATE OF STILLBIRTH **158** Reg. Dist. No.

A certificate must be filed within 24 hours for every stillbirth of 20 weeks' gestation or more (see stub)

## 1. PLACE OF BIRTH:

County St. Marys

City or town NAS, Patuxent River, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street address, hospital, or institution:

NAS Dispensary, Patuxent River, Md.

Length of mother's stay in County 15 years.

(How many years, or months, or days. SPECIFY WHICH)

## 3. Name of child Baby Girl McDONALD (Unnamed)

## 5. Sex Female | 6. Twin or triplet --

## FATHER OF CHILD

8. Full name Vincent McDONALD

9. Color White 10. Age at time of this birth 26 yrs.

11. Usual occupation U. S. Navy

16. Other children born to mother (not including present child): (a) How many children of this mother are now living? 0  
 (b) How many other children were born alive but are now dead? 0 (c) How many other children were born dead? 0

17. Did child die before labor? No During labor? No

18. Pregnancy, complications of None

19. Labor: (a) Complications of None

(b) Induced?

20. (a) Was there an operation for delivery? Yes

(Yes or No)

(b) State all operations, if any

Episiotomy - Low forceps

(c) Did child die before operation? No

During operation? No

23. (a) Transportation Date thereof 10/4/48  
 (Burial, cremation or removal) (month) (day) (year)

(c) Cemetery or crematory Baltimore, Md.

24. (a) Funeral director P.B. Robinson

(b) Address Leonardtown, Md.

## 2. USUAL RESIDENCE OF MOTHER:

State Maryland

County Baltimore

City or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 5906 Bertram Ave.

(If RURAL give LOCATION)

4. Date of birth 3 October 1948 Hour 2:25 A.M.

7. No. of weeks pregnancy Full Term

## MOTHER OF CHILD

12. Full maiden name Doris MALKUS

13. Color White 14. Age at time of this birth 23 yrs.

15. Usual occupation Home maker

21. Cause of stillbirth. Please be specific. For terms like prematurity, asphyxia, etc., try to add cause thereof.

(a) Fetal causes Respiratory arrest

(b) Maternal causes None apparent

22. I certify to the birth of this child who was born dead\* on the date and hour above stated

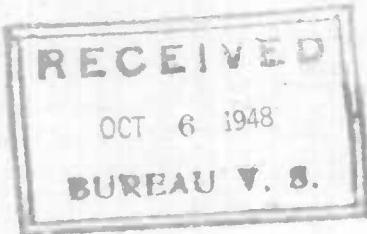
Signature M.J. COSTIK, LTJG MCR USNR  
 (Specify if M.D., midwife, or other)

Address Dispensary, NAS, Patuxent River, Md.

25. (a) 1014148 (b) Cacanee  
 (Date rec'd by registrar) (Registrar)26. (To be filled out if no physician was present at delivery.)  
 The above certificate has been examined by me.

Health Officer, per

\* See Instruction C on stub.



10731

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 288

M  
ARGIN RESERVED FOR BINDING  
PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## 1. PLACE OF DEATH:

County *St. Mary's*City or town *Leonardtown*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? *Two weeks*Hospital, institution, or street address where death occurred: *St. Mary's Hosp. Leonardtown, Md.*How long in hospital or institution? *Two weeks*

## 3. (a) FULL NAME

*JOHN PARKER*

## 4. Sex

## 5. Color or race

## 6.(a) Single, married, widowed, or divorced

*Male**Colored married*

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Md.*County *St. Mary's*City or town *Oakley*

(If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_

(If rural, give LOCATION)

## 2.(a) If veteran, name war \_\_\_\_\_

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

*18 October**48**at 4:00 p.m.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

*9 Oct**48**to 12 Oct 48*and that I last saw h. m. alive on *12 Oct**19 48*

## Immediate cause of death

*Lobar pneumonia*

DURATION

*3 day*

Due to

Due to

## Other conditions

(Include pregnancy within 3 months of death)

## Major findings or operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

Injured at home, farm, industry, public place (where?) .....

## Means of injury

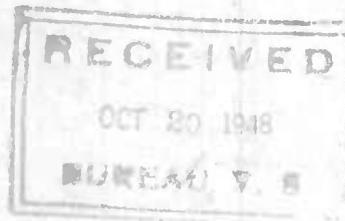
Injured at work?

## 23. SIGNATURE

*Roy G. Guther, M.D.*

M. D. or other

Address *Mechanicsville* Date signed *18 Oct 48*



Evidence for addition of MARYLAND STATE DEPARTMENT OF HEALTH  
the birth date shown on:

2411 N. Charles St., Baltimore

10732

FILM No. G 117 OCT 26 1948

CERTIFICATE OF DEATH

Reg. Dist. No. 284

1. PLACE OF DEATH:

County St. Mary's

City or town Rural - near Mechanicsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

LAWRENCE LINTHICUM

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND

County St. Mary's

City or town Rural - Nr. MECHANICSVILLE

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

20 Oct

19 48 at 7 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

4 Oct

19 48 to 20 Oct 19 48

and that I last saw h. m. alive on

19 Oct

19 48

Immediate cause of death

Coronary insufficiency  
(cystic atherosclerosis)

DURATION

1 year

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

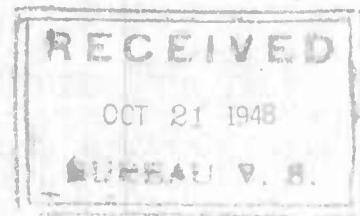
Injured at work?

23. SIGNATURE

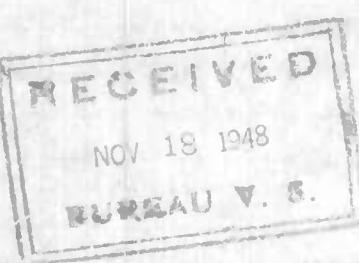
J. Roy Lintner, MD

M. D. or other

Address Oberlinville Date signed 20 Oct 48







I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10734

## CERTIFICATE OF DEATH

282

Reg. Dist. No.....

## 1. PLACE OF DEATH:

County..... St. Marys

City or town..... ( Rural ) Loveville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Annie Veronica Somerville

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

female colored single

6.(b) Name of husband or wife

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

April 10, 1904

8. AGE:

Years  
44

Months

Days

If less than one day

..... hrs. ..... min.

9. Birthplace.....

Maryland

(Town, county, and state)

10. Usual occupation.....

Housekeeper

11. Industry or business

12. Name..... James T. Somerville

13. Birthplace..... Maryland

14. Maiden name..... Heneritta J. Somerville

15. Birthplace..... Maryland

16. Informant..... Bernard A. Somerville

Address Loveville, Maryland

Burial

Date thereof..... 10/26/48

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory..... St. Joseph

Location Morganza, Maryland

18. Funeral director..... P.B. Robinson

Address Leonardtown, Maryland

19. 10/25/48 Casualty

(Date read by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... St. Marys

City or town..... Loveville ( rural )

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

October 23

19

48

6:45 P

2D. DATE OF DEATH.....

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 19 48 to Oct 19 48

and that I last saw her alive on Oct. 22 1948

Immediate cause of death.....

Cerebral Hemorrhage

DURATION

3 yr -

Due to.....

Due to.....

Other conditions..... General malnutrition

(Include pregnancy within 3 months of death)

Major findings of operations..... absent

Date of op.....

Autopsy results..... none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, Indusfr, public place (where?)

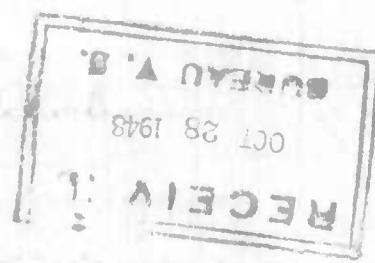
Means of injury

Injured at work?

23. SIGNATURE.....

M. D. or other

Address..... Chaptico Md. Date signed..... 10/25/48



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10735

Reg. Dist. No. 2

## CERTIFICATE OF DEATH

95c

## 1. PLACE OF DEATH:

County..... St. Marys, Md.

City or town..... Mechanicsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 4 yrs.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Doshia D. Thompson

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
female	white	widowed

6. (b) Name of husband or wife.....

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) February 22, 1873

8. AGE: Years	Months	Days	If less than one day
75			....hrs. ....min.

9. Birthplace..... Maryland  
(Town, county, and state)

10. Usual occupation..... None

## 11. Industry or business

12. Name..... Alexander Hancock

13. Birthplace..... Maryland

14. Maiden name..... Elenor Davis

15. Birthplace..... Maryland

16. Informant..... Guy F. Hill

Address..... Mechanicsville, Md.

17. Burial..... Date thereof..... 10/8/48  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... All Faith

Location..... Charlotte Hall, Md.

18. Funeral director..... P. B. Robinson

Address..... Leonardtown, Md.

19. (Date rec'd by registrar) 10/7/48 C. G. C. (Signature)  
Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... St. Marys

City or town..... Mechanicsville  
(If outside city or town limits, write RURAL and give nearest town)Street No. ....  
(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... October 6 1948 10:30 A.M.

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from

Oct. 15 1948 to Oct. 5 1948  
and that I last saw her alive on Oct. 4 1948

Immediate cause of death.....

Chronic Cardiac 7

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury.....

Injured at work? .....

23. SIGNATURE.....

Alayson C. Welch  
Chester, Md. M. D. or other  
Address..... Date signed..... 10/6/48

**RECEIVED**  
OCT 11 1948  
**BUREAU V. S.**

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

176

Reg. Dist. No.

282

## 1. PLACE OF DEATH:

County..... St. Marys  
 City or town..... Hollywood (rural)  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

George Alfred Wathen

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife.....

...6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) Aprial 30, 1928

8. AGE: Years	Months	Days	If less than one day
20	5	14	hrs. min.

9. Birthplace..... Maryland  
(Town, county, and state)

10. Usual occupation..... Laborer &amp; truck driver

11. Industry or business..... Lumber Mill

12. Name..... John W. Wathen

13. Birthplace..... Maryland

14. Maiden name..... Anna M. Long

15. Birthplace..... Maryland

16. Informant..... John W. Wathen

Address..... R.F.D. Hollywood, Md.

17. Burial..... Date thereof..... 10/16/48  
(Burial, cremation, or removal. Which?)

Cemetery or crematory..... St. Aloysius

Location..... Leonardtown, Md.

18. Funeral director..... P.B. Robinson

Address..... Leonardtown, Md.

19. (Date rec'd by registrar) 10/15-48

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... St. Marys  
 City or town..... R.F.D. Hollywood  
(If outside city or town limits, write RURAL and give nearest town)  
 Street No.....  
(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... October 14 1948 9:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
*Deed when first seen.* 19..... 19.....  
 and that I last saw h..... alive on..... 19..... 19.....

Immediate cause of death.....

*Extreme head injury*

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Where did injury occur?.....

(City or town)..... (County)..... (State).....

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?.....

23. SIGNATURE.....

M. D. or other.....

Address..... Leonardtown, Md. Date signed 10/15/48

From report of Motor-Vehicle Acc. (Comm. of M.V.) - "Deceased had body of veh. hoisted up and was working on same when hoist gave way and fell on victim. (non-traffic)



PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully; the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10737

## CERTIFICATE OF DEATH

Reg. Dist. No. 282

## 1. PLACE OF DEATH:

County

St. Marys

City or town

New Leonardtown Maryland

How long in above place of death? 30 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

John T. Wathen

4. Sex

5. Color or race

B.(a) Single, married, widowed, or divorced

male white Widowed

6. (b) Name of husband or wife Margaret M. Wathen

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

March 15 - 1866

8. AGE: Years Months Days If less than one day

82 7 12 hrs. min.

9. Birthplace Charles Maryland

(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business same

12. Name Benedict Wathen

13. Birthplace Charles Co

14. Maiden name Jenkins

15. Birthplace Charles Co

16. Informant Mitchell Wathen

Address Leonardtown Maryland

17. Burial Cemetery

Location Leonardtown Maryland

18. Funeral director W.C. Maltzley Son

Address Leonardtown Maryland

19. Date rec'd by registrar 10/29/48

Date signed 10/29/48

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County

St. Marys

Street No. 97-A

Floor

2

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 27 1948 at 6:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Mar 1944 to Oct 27 1948

and that I last saw him alive on Oct 26 1948

Immediate cause of death cardiovascular disease

Duration 48 hours

Due to

Cause of death cerebral hemorrhage 5 yrs

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Francis F. Greenwell

M. D. or other

Address Leonardtown Maryland Date signed Oct 29/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness of the information given is especially important. Physicians, please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10738

## CERTIFICATE OF DEATH

1318  
Reg. Dist. No. ....

282

## 1. PLACE OF DEATH:

County..... St. Marys

City or town..... Leonardtown, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred: St. Marys Hospital

How long in hospital or Institution?..... 4 Days.....

## 3. (a) FULL NAME

Alice Belle Weasenforth

## 3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female

White

Married

6. (b) Name of husband or wife..... William H. Weasenforth

6. (c) If alive, give age..... 71 years

7. Birth date of deceased (mo. day, yr.)

May 6 1881

8. AGE: Years

Months

Days

If less than one day

67

....hrs.

....min.

9. Birthplace..... Indiana

(Town, county, and state)

10. Usual occupation.....

Housewife

11. Industry or business

12. Name..... George F Brown

13. Birthplace..... Unknown

14. Maiden name..... Annie Smith

15. Birthplace..... Penn

16. Informant..... William H. Weasenforth

Address..... St. Inigoes, Md.

17. Removal.....

(Burial, cremation, or removal. Which?)

Date thereof..... Oct 16 1948

(month) (day) (year)

Cemetery or crematory.....

Location..... Keyser, West Virginia

18. Funeral director..... P. B. Robinson

Address..... Leonardtown, Md.

19. Date rec'd by registrar..... 10/15/48

(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... St. Marys

City or town..... St. Inigoes

(If outside city or town limits, write RURAL and give nearest town)

Street No..... (If rural, give LOCATION)

2. (a) If veteran, name war.....

## MEDICAL CERTIFICATION

2D. DATE OF DEATH..... Oct 15 1948 at 1:30A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

10-7 1948 to 10-15 1948

and that I last saw her alive on 10-14 1948

Immediate cause of death.....

Pneumonia

DURATION

2 days

Due to.....

Influenza

20 days

Due to.....

Empyema of gall bladder

?

Other conditions.....

Chronic Nephritis

?

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury.....

Injured at work? .....

23. SIGNATURE..... E. Thompson M.D.

M. D. or other

Address..... Lexington Park Date signed..... 10-15-48

